LOS ANGELES KNEE AND SPORTS MEDICINE CLINIC
MICHAEL R. SHAPIRO, MD

GENERAL PATIENT INFORMATION FORM

Patient Name:_____ Sex:_____ Birth Date:_____ Age:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Drivers License #:_____

Employer:_____ Work Phone:_____

Employers Address:_____

Social Security #:_____ Occupation:_____

Name of Spouse:_____ Work Phone:_____

Employer of Spouse:_____

Referred By:_____ Phone #:_____

In Case of Emergency Contact:_____ Phone #:_____

Address:_____ Relationship:_____

Insurance Carrier:_____ Phone #:_____

Address:_____

Name of Insured:_____ Policy #:_____

Cert.#:_____ Group #:_____ Relationship to Insured:_____

If Injured, Was Injury Related to Work:_____ Auto Accident:_____

Date of Injury:_____ Where did Injury Occur?:_____

Attorney Name:_____ Phone #:_____

Address:_____

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I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS PAYABLE TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE MICHAEL R. SHAPIRO M.D. TO EXAMINE ME. I UNDERSTAND THAT IF SURGERY IS INDICATED, PAYMENT ARRANGEMENTS WILL BE MADE AND I AM RESPONSIBLE FOR MY BILL REGARDLESS OF INSURANCE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

SIGNED:_____ DATE:_____

SIGNATURE OF PARENT OR GUARDIAN:_____ RELATIONSHIP:_____